AMENDED IN SENATE APRIL 3, 2014

AMENDED IN SENATE JUNE 18, 2013

AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1340

Introduced by Assembly Member Achadjian
(Coauthor: Assembly Member Yamada)
(Coauthors: Senators Beall and Wolk)

February 22, 2013

An act to amend ~~Sections 1180.1 and 1180.2 of, and to add Section 1255.9 to,~~ *Section 1250 of, and to add Section 1265.9 to,* the Health and Safety Code, and to amend Sections 4100 and 7200 of, and to add Sections 4142~~, 4143, and 4144~~ *and 4143* to, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1340, as amended, Achadjian. ~~State Hospital Employees Act.~~ *Enhanced treatment programs.*

Existing law establishes state hospitals for the care, treatment, and education of mentally disordered persons. These hospitals are under the jurisdiction of the State Department of State Hospitals, which is authorized by existing law to adopt regulations regarding the conduct and management of these facilities. Existing law requires each state hospital to develop an incident reporting procedure that can be used to,

at a minimum, develop reports of patient assaults on employees and assist the hospital in identifying risks of patient assaults on employees. Existing law provides for the licensure and regulation of health facilities, including acute psychiatric hospitals, by the State Department of Public Health. A violation of these provisions is a crime.

~~This bill would establish an Enhanced Treatment Facility and specified programs within the State Department of State Hospitals, and subject to available funding, would require each state hospital to establish and maintain an enhanced treatment unit (ETU) as part of its facilities. The bill would authorize an acute psychiatric hospital under the jurisdiction of the department to be licensed to offer an ETU that meets specified requirements, including that each room be limited to one patient, and would authorize the department to adopt and implement policies and procedures, as specified. Because the bill would create a new crime, it imposes a state-mandated local program.~~

~~The bill would also require any case of assault by a patient of a state hospital, as specified, to be immediately referred to the local district attorney, and if, after the referral, the patient is found guilty of a misdemeanor or a felony assault, the local district attorney declines to prosecute, or the patient is found incompetent to stand trial or not guilty by reason of insanity, the bill would require the patient to be placed in the ETU of the hospital until the patient is deemed safe to return to the regular population of the hospital.~~

~~The bill would authorize a state hospital psychiatrist or psychologist to refer a patient to an ETU for temporary placement and risk assessment upon determining that the patient may pose a substantial risk of inpatient aggression. The bill would require a forensic needs assessment panel (FNAP) to conduct a placement evaluation to determine whether the patient meets the threshold standard for treatment in an enhanced treatment program (ETP). The bill would require, if the FNAP determines that the ETU placement is appropriate, that the FNAP certify the patient for 90 days of ETP placement and provide the determination in writing to the patient and the patient's advocate. The bill would also require a forensic needs assessment team (FNAT) psychologist to perform an in-depth clinical assessment and make a treatment plan upon the patient's admission to an ETP. The bill would require the FNAP to meet with specified individuals to determine whether the patient may stay in the ETP placement or return to a standard security treatment setting and provide the determination in writing to the patient's advocate. If the FNAP determines the patient is no longer appropriate for ETP~~

~~placement, the FNAP may refer the patient to the 7-day step down unit, as defined, or a standard security setting in a department hospital.~~

This bill would, commencing July 1, 2015, and subject to available funding, authorize the State Department of State Hospitals to establish and maintain enhanced treatment programs (ETPs), as defined, for the treatment of patients who are at high risk for most dangerous behavior, as defined, and when treatment is not possible in a standard treatment environment. The bill would require, until January 1, 2018, that an ETP meet the licensing requirements of an acute psychiatric hospital, except as specified. Commencing January 1, 2018, an ETP that is operated by the State Department of State Hospitals would be required to be licensed by the State Department of Public Health.

The bill would authorize a state hospital psychiatrist or psychologist to refer a patient to an ETP for temporary placement and risk assessment upon a determination that the patient may be at high risk for most dangerous behavior. The bill would require the forensic needs assessment panel (FNAP) to conduct a placement evaluation to determine whether the patient clinically requires ETP placement and ETP treatment can meet the identified needs of the patient. The bill would also require a forensic needs assessment team (FNAT) psychologist to perform an in-depth violence risk assessment and make a treatment plan upon the patient's admission to an ETP.

The bill would require the FNAP to conduct a treatment placement meeting with specified individuals prior to the expiration of 90 days from the date of placement in the ETP to determine whether the patient may return to a standard treatment environment or the patient clinically requires continued ETP treatment. If the FNAP determines that the patient clinically requires continued ETP treatment, the bill would require the FNAP to certify the patient for further ETP treatment for one year, subject to FNAP reviews every 90 days, as specified. The bill would require the FNAP to conduct another treatment placement meeting prior to the expiration of the one-year certification of ETP placement to determine whether the patient may return to a standard treatment environment or be certified for further ETP treatment for another year.

Because this bill would create a new crime, it imposes a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that the State Department of State Hospitals delivers inpatient mental health treatment to over 6,000 patients through more than 10,000 department employees. Their goal is to improve the lives of patients diagnosed with severe mental health conditions who have been assigned to their hospitals and units. In the experience of the department, there can be no effective clinical treatment without safety for its patients and employees, and no safety without effective clinical treatment.

(b) It is the intent of the Legislature in enacting this bill to expand the range of available clinical treatment by establishing enhanced treatment programs for those patients determined to be at the highest risk for aggression against other patients or hospital staff. The goal of these enhanced treatment programs is to deliver concentrated, evidence-based clinical therapy, and treatment in an environment designed to improve these patients' conditions and return them to the general patient population.

SEC. 2. Section 1250 of the Health and Safety Code is amended to read:

1250. As used in this chapter, "health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

(a) "General acute care hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care

hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section.

A "general acute care hospital" includes a "rural general acute care hospital." However, a "rural general acute care hospital" shall not be required by the department to provide surgery and anesthesia services. A "rural general acute care hospital" shall meet either of the following conditions:

(1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982.

(2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

(b) "Acute psychiatric hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that

provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(c) (1) "Skilled nursing facility" means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(2) "Skilled nursing facility" includes a "small house skilled nursing facility (SHSNF)," as defined in Section 1323.5.

(d) "Intermediate care facility" means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

(e) "Intermediate care facility/developmentally disabled habilitative" means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

(f) "Special hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

(g) "Intermediate care facility/developmentally disabled" means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

(h) "Intermediate care facility/developmentally disabled-nursing" means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but

have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons with developmental disabilities or who demonstrate significant developmental delay that may lead to a developmental disability if not treated.

(i) (1) "Congregate living health facility" means a residential home with a capacity, except as provided in paragraph (4), of no more than 12 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

(2) Congregate living health facilities shall provide one of the following services:

(A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

(B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A "life-threatening illness" means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

(C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

(3) A congregate living health facility license shall specify which of the types of persons described in paragraph (2) to whom a facility is licensed to provide services.

(4) (A) A facility operated by a city and county for the purposes of delivering services under this section may have a capacity of 59 beds.

(B) A congregate living health facility not operated by a city and county servicing persons who are terminally ill, persons who have been diagnosed with a life-threatening illness, or both, that is located in a county with a population of 500,000 or more persons, or located in a county of the 16th class pursuant to Section 28020 of the Government Code, may have not more than 25 beds for the purpose of serving persons who are terminally ill.

(C) A congregate living health facility not operated by a city and county serving persons who are catastrophically and severely disabled, as defined in subparagraph (C) of paragraph (2) that is located in a county of 500,000 or more persons may have not more than 12 beds for the purpose of serving persons who are catastrophically and severely disabled.

(5) A congregate living health facility shall have a noninstitutional, homelike environment.

(j) (1) "Correctional treatment center" means a health facility operated by the Department of Corrections and Rehabilitation, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by the department, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services. This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards who may be receiving outpatient services and are housed separately for reasons of improved access to health care, security, and protection. The health services provided by a correctional treatment center shall include, but are not limited to, all of the following basic services: physician and surgeon, psychiatrist, psychologist, nursing, pharmacy, and dietary. A correctional treatment center may provide the following services: laboratory, radiology, perinatal, and any other services approved by the department.

(2) Outpatient surgical care with anesthesia may be provided, if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204, with the exception of the requirement that patients remain less than 24 hours.

(3) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

(4) Physician and surgeon services shall be readily available in a correctional treatment center on a 24-hour basis.

(5) It is not the intent of the Legislature to have a correctional treatment center supplant the general acute care hospitals at the California Medical Facility, the California Men's Colony, and the California Institution for Men. This subdivision shall not be construed to prohibit the Department of Corrections and Rehabilitation from obtaining a correctional treatment center license at these sites.

(k) "Nursing facility" means a health facility licensed pursuant to this chapter that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) or as a nursing facility in the federal Medicaid Program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or as both.

(*l*) Regulations defining a correctional treatment center described in subdivision (j) that is operated by a county, city, or city and county, the Department of Corrections and Rehabilitation, or the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall not become effective prior to, or if effective, shall be inoperative until January 1, 1996, and until that time these correctional facilities are exempt from any licensing requirements.

(m) "Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)" means a homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. ICF/DD-CN facilities shall be subject to licensure under this chapter upon adoption of licensing regulations in accordance with Section 1275.3. A facility providing continuous

skilled nursing services to persons with developmental disabilities pursuant to Section 14132.20 or 14495.10 of the Welfare and Institutions Code shall apply for licensure under this subdivision within 90 days after the regulations become effective, and may continue to operate pursuant to those sections until its licensure application is either approved or denied.

(n) "Hospice facility" means a health facility licensed pursuant to this chapter with a capacity of no more than 24 beds that provides hospice services. Hospice services include, but are not limited to, routine care, continuous care, inpatient respite care, and inpatient hospice care as defined in subdivision (d) of Section 1339.40, and is operated by a provider of hospice services that is licensed pursuant to Section 1751 and certified as a hospice pursuant to Part 418 of Title 42 of the Code of Federal Regulations.

(o) (1) "Enhanced treatment program" or "ETP" means a health facility under the jurisdiction of the State Department of State Hospitals that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients who have been committed to the State Department of State Hospitals and have been assessed to be at high risk for most dangerous behavior, as defined in subdivision (k) of Section 4143 of the Welfare and Institutions Code, and cannot be effectively treated within an acute psychiatric hospital, a skilled nursing facility, or an intermediate care facility, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary service.

(2) It is not the intent of the Legislature to have an enhanced treatment program supplant health facilities licensed as an acute psychiatric hospital, a skilled nursing facility, or an intermediate care facility under this chapter.

(3) Commencing July 1, 2015, and until January 1, 2018, an enhanced treatment program shall meet the licensing requirements applicable to acute psychiatric hospitals under Chapter 2 (commencing with Section 71001) of Division 5 of the California Code of Regulations, unless otherwise specified in Section 1265.9 and any related emergency regulations adopted pursuant to that section.

(4) Commencing January 1, 2018, an ETP shall be subject to licensure under this chapter as specified in subdivision (a) of Section 1265.9.

SEC. 3. Section 1265.9 is added to the Health and Safety Code, to read:

1265.9. (a) On and after January 1, 2018, an enhanced treatment program (ETP) that is operated by the State Department of State Hospitals shall be licensed by the State Department of Public Health to provide treatment for patients who are at high risk for most dangerous behavior, as defined by subdivision (k) of Section 4143 of the Welfare and Institutions Code. Each ETP shall be part of a continuum of care based on the individual patient's treatment needs.

(b) (1) Notwithstanding subdivision (a), commencing July 1, 2015, and until January 1, 2018, the State Department of State Hospitals may establish and maintain an ETP for the treatment of patients who are at high risk for most dangerous behavior, as described in Section 4142 of the Welfare and Institutions Code, if the ETP meets the licensing requirements applicable to acute psychiatric hospitals under Chapter 2 (commencing with Section 71001) of Division 5 of the California Code of Regulations, unless otherwise specified in this section or emergency regulations adopted pursuant to paragraph (2).

(2) Prior to January 1, 2018, the State Department of State Hospitals may adopt emergency regulations in accordance with the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to implement this section. The adoption of an emergency regulation under this paragraph is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of State Hospitals is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(c) An ETP shall meet all of the following requirements:

(1) Maintain a staff-to-patient ratio of one-to-five.

(2) Limit each room to one patient.

(3) Each patient room shall allow visual access by staff 24 hours per day.

(4) Each patient room shall have a bathroom in the room.

(5) Each patient room door shall have the capacity to be locked externally. The door may be locked when clinically indicated and determined to be the least restrictive environment for provision of the patient's care and treatment pursuant to Section 4143 of the

Welfare and Institutions Code, but shall not be considered seclusion for purposes of Division 1.5 (commencing with Section 1180).

(6) Provide emergency egress for ETP patients.

(d) The ETP shall adopt and implement policies and procedures consistent with regulations adopted by the State Department of State Hospitals that provide all of following:

(1) Policies and procedures for admission into the ETP.

(2) Clinical assessment and review focused on behavior, history, dangerousness, and clinical need for patients to receive treatment in the ETP.

(3) A process for identifying which ETP along a continuum of care will best meet the patient's needs.

(4) A process for a treatment plan with regular clinical review and reevaluation of placement back into a standard treatment environment that includes discharge and reintegration planning.

(e) Patients who have been admitted to an ETP shall have the rights guaranteed to patients not in an ETP with the exception set forth in paragraph (5) of subdivision (c).

(f) (1) Commencing January 1, 2018, the department shall monitor the ETPs, evaluate outcomes, and report on its findings and recommendations to the Legislature, in compliance with Section 9795 of the Government Code, every two years.

(2) The requirement for submitting findings and recommendations to the Legislature every two years under paragraph (2) is inoperative on January 1, 2026.

(g) Notwithstanding paragraph (2) of subdivision (b), the State Department of Public Health and the State Department of State Hospitals shall jointly develop the regulations governing ETPs.

SEC. 4. Section 4100 of the Welfare and Institutions Code is amended to read:

4100. The department has jurisdiction over the following institutions:

(a) Atascadero State Hospital.

(b) Coalinga State Hospital.

(c) Metropolitan State Hospital.

(d) Napa State Hospital.

(e) Patton State Hospital.

(f) Any other State Department of State Hospitals facility subject to available funding by the Legislature.

SEC. 5. Section 4142 is added to the Welfare and Institutions Code, to read:

4142. Commencing July 1, 2015, and subject to available funding, the State Department of State Hospitals may establish and maintain enhanced treatment programs (ETPs), as defined in subdivision (o) of Section 1250 of the Health and Safety Code, for the treatment of patients described in Section 4143.

SEC. 6. Section 4143 is added to the Welfare and Institutions Code, to read:

4143. (a) A state hospital psychiatrist or psychologist may refer a patient to an enhanced treatment program (ETP), as defined in subdivision (o) of Section 1250 of the Health and Safety Code, for temporary placement and risk assessment upon determining that the patient may be at high risk for most dangerous behavior and when treatment is not possible in a standard treatment environment. The referral may occur at any time after the patient has been admitted to a hospital or program under the jurisdiction of the department, with notice to the patient's advocate at the time of the referral.

(b) Within three business days of placement in the ETP, a dedicated forensic evaluator, who is not on the patient's treatment team, shall complete an initial evaluation of the patient that shall include an interview of the patient's treatment team, an analysis of diagnosis, past violence, current level of risk, and the need for enhanced treatment.

(c) (1) Within seven business days of placement in an ETP and with 72-hour notice to the patient and patient's advocate, the forensic needs assessment panel (FNAP) shall conduct a placement evaluation meeting with the referring psychiatrist or psychologist, the patient and patient's advocate, and the dedicated forensic evaluator who performed the initial evaluation. A determination shall be made as to whether the patient clinically requires ETP treatment.

(2) (A) The threshold standard for treatment in an ETP is met if a psychiatrist or psychologist, utilizing standard forensic methodologies for clinically assessing violence risk, determines that a patient meets the definition of a patient at risk for most dangerous behavior and ETP treatment can meet the identified needs of the patient.

(B) Factors used to determine a patient's high risk for most dangerous behavior may include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.

(3) If a patient has shown improvement during his or her placement in the ETP, the FNAP may delay its decision for another seven business days. The FNAP's determination of whether the patient will benefit from continued or longer term ETP placement and treatment shall be based on the threshold standard for treatment in an ETP specified in subparagraph (A) of paragraph (2).

(d) (1) The FNAP shall review all material presented at the FNAP placement evaluation meeting conducted under subdivision (c), and the FNAP shall either certify the patient for 90 days of treatment in an ETP or direct that the patient be returned to a standard treatment environment in the hospital.

(2) After the FNAP makes a decision to provide ETP treatment and if the ETP treatment will be provided at a facility other than the current hospital, the transfer may take place as soon as transportation may reasonably be arranged and no later than 30 days after the decision is made.

(3) The FNAP determination shall be in writing and provided to the patient and patient's advocate as soon as possible, but no later than three business days after the decision is made.

(e) (1) Upon admission to the ETP, a forensic needs assessment team (FNAT) psychologist who is not on the patient's treatment team shall perform an in-depth violence risk assessment and make a treatment plan for the patient based on the assessment within 14 business days of placement in the ETP. Formal treatment plan reviews shall occur on a monthly basis, which shall include a full report on the patient's behavior while in the ETP.

(2) An ETP patient shall receive treatment from a team consisting of a psychologist, a psychiatrist, a nurse, and a psychiatric technician, a clinical social worker, a rehabilitation therapist, and any other staff as necessary, who shall meet as often as necessary, but no less than once a week, to assess the patient's response to treatment in the ETP.

(f) Prior to the expiration of 90 days from the date of placement in the ETP and with 72-hour notice provided to the patient and

the patient's advocate, the FNAP shall convene a treatment placement meeting with a psychologist from the treatment team, a patient advocate, the patient, and the FNAT psychologist who performed the in-depth violence risk assessment. The FNAP shall determine whether the patient may return to a standard treatment environment or the patient clinically requires continued treatment in the ETP. If the FNAP determines that the patient clinically requires continued ETP placement, the patient shall be certified for further ETP placement for one year. The FNAP determination shall be in writing and provided to the patient and the patient's advocate within 24 hours of the meeting. If the FNAP determines that the patient is ready to be transferred to a standard treatment environment, the FNAP shall identify appropriate placement within a standard treatment environment in a state hospital, and transfer the patient within 30 days of the determination.

(g) If a patient has been certified for ETP treatment for one year pursuant to subdivision (f), the FNAP shall review the patient's treatment summary every 90 days to determine if the patient no longer clinically requires treatment in the ETP. This FNAP determination shall be in writing and provided to the patient and the patient's advocate within three business days of the meeting. If the FNAP determines that the patient no longer clinically requires treatment in the ETP, the FNAP shall identify appropriate placement, and transfer the patient within 30 days of the determination.

(h) Prior to the expiration of the one year certification of ETP placement under subdivision (f), and with 72-hour notice provided to the patient and the patient's advocate, the FNAP shall convene a treatment placement meeting with the treatment team, the patient advocate, the patient, and the FNAT psychologist who performed the in-depth violence risk assessment. The FNAP shall determine whether the patient clinically requires continued ETP treatment. If after consideration, including discussion with the patient's ETP team members and review of documents and records, the FNAP determines that the patient clinically requires continued ETP placement, the patient shall be certified for further treatment for an additional year. The FNAP determination shall be in writing and provided to the patient and the patient's advocate within three business days of the meeting.

(i) At any point during the ETP placement, if a patient's treatment team determines that the patient no longer clinically requires ETP treatment, a recommendation to transfer the patient out of the ETP shall be made to the FNAT or FNAP.

(j) The process described in this section may continue until the patient no longer clinically requires ETP treatment or until the patient is discharged from the state hospital.

(k) As used in this section, the following terms have the following meanings:

(1) "Enhanced treatment program" or "ETP" means a health facility as defined in subdivision (o) of Section 1250 of the Health and Safety Code.

(2) "Forensic needs assessment panel" or "FNAP" means a panel that consists of a psychiatrist, a psychologist, and the medical director of the hospital or facility, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement meetings.

(3) "Forensic needs assessment team" or "FNAT" means a panel of psychologists with expertise in forensic assessment or violence risk assessment, each of whom are assigned an ETP case or group of cases.

(4) "In-depth violence risk assessment" means the utilization of standard forensic methodologies for clinically assessing the risk of a patient posing a substantial risk of inpatient aggression.

(5) "Patient advocate" means the advocate contracted under Sections 5370.2 and 5510.

(6) "Patient at high risk of most dangerous behavior" means the individual has a history of physical violence and currently poses a demonstrated danger of inflicting substantial physical harm upon others in an inpatient setting, as determined by an in-depth violence risk assessment conducted by the State Department of State Hospitals.

SEC. 7. Section 7200 of the Welfare and Institutions Code is amended to read:

7200. There are in the state the following state hospitals for the care, treatment, and education of the mentally disordered:

(a) Metropolitan State Hospital near the City of Norwalk, Los Angeles County.

(b) Atascadero State Hospital near the City of Atascadero, San Luis Obispo County.

(c) Napa State Hospital near the City of Napa, Napa County.

(d) Patton State Hospital near the City of San Bernardino, San Bernardino County.

(e) Coalinga State Hospital near the City of Coalinga, Fresno County.

(f) Any other State Department of State Hospitals facility subject to available funding by the Legislature.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, June 18, 2013. (JR11)

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